MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11467 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY Howard o. STATE b. COUNTY 2, and 3 to PM3. Page Deportment of death. MARYLAND Maryland Howard delay b. CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b write RURAL and give nearest town) Ellicott City Ellicott City d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? form hours 109 N.St. Johns Lane 109 N. St. Johns Lane YES NO X e Item 18. Give Pages 24 hours ofter death. Middle 3. NAME OF 4 DATE Year DECEASED 0F Within CHARLES DEATH (Type or print) Office alang AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last birthdoy) Hours WIDOWED DIVORCED Dec. 11.1904 event Male White 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
C. P. Telephone Co. INDUSTRY COLINTRY? Kentucky e, writing the word "pending" in pencil in forwarded to the Chief Medical Exominer's 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within = Lelia Mc Rae Resin D. Gray 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give war or dotes of service) removal. Carl W. Krammer , Sykesville . Md Rt. 1 Box 114 No 252-03-8514 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: pronan or IMMEDIATE CAUSE (o) This certificate should cremation, DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION YES NO 🔀 9 pe 4 should be 20o. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PRIMARY I or CONTRIBUTING I CAUSE OF DEATH. (County) (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Not While at work at work its designoted 21. I certify that I took charge of the remains described above, held an Autopsy Inspection 🖂 Inquiry 🔀 ond in my opinion Notural couses Suicide . deoth resulted\_from: Accident Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SLONED ASSISTANT MEDICAL EXAMINER SIGNATURE 44 Church Rd 5 moy be ro FUNERAL Health or i DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) Ellicati Ch Ma NAME (Type) 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, REMOVAL (Specify) Baltimore Md

TRAR 2Sb. REGISTRAR'S SIGNATURE Lorraine 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) Milanles AUG 1966 F.C. Higinbothom, Ellicott

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FOR STATE HEALTH DEPT. necessory, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 ta the funeral director. Page 4 should be farworded to the Chief Medical Examiner's Office along with form PM3. Page any delay is in any event within 72 hours ofter death. pages 1 and 2 with the State Department This certificate should be executed within 24 hours ofter death. If Health or its designated agent, prior to buriol, cremation, or removal, and TO FUNERAL DIRECTOR: Page 3 should be used as a buriol-transit permit. TO DEPUTY MEDICAL EXAMINER: 5 may be retained for your files.

VR A15ME (S)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11	468	MED	ICAL EXAMIN	IER'S					114	llid		
1. PLACE OF a. COUNTY					2. USUAL RESIDENCE o. STATE	(Where deceased liv	ved, if institution	on: Residence	before	odmission)		
a. cooliii	Howard		MARY	LAND	o. STATE Maryland Howard							
	TOWN (If outside corporate limi	ts,	c. LENGTH OF STAY II	N 1b	c. CITY OR TOWN (If	outside corporate lin	nits, write RUR	AL ond give	neore st	town)		
write K	URAL ond give neorest town) Ellicott C	itv			Ellico	tt City				3-1		
d. NAME O	F HOSPITAL OR INSTITUTION (If n	ot in hospital, g	ive street oddress)		d. STREET ADDRESS					e. IS RESIDENCE		
	3 No. Penf				3 N D	enfield R	ond		YE	ON A FARM?		
3. NAME OF		irst	Middle		Lost	4. DATE	Month		Dov	Year		
DECEASED (Type or p						OF						
5. SEX	6. COLOR OR RACE	RIAN 7. MARRIED :	H. NEVER MARRIED		KELLY  DATE OF BIRTH	DEATH 9 AGI	E (In years	IF LINDER 1 V	30	19 <b>66</b> F UNDER 24 HRS.		
Fema		WIDOWED	DIVORCED	느ㅣ	. DAIL OF DIKIT	los	63 yrs.			Hours Min.		
during most of	CUPATION (Give kind of work done working life, even if retired)		ND OF BUSINESS OR DUSTRY		11. BIRTHPLACE (Sto		1)	12. CITIZ COUN	EN OF W	VHAT		
13. FATHER'S	Home				14. MOTHER'S MAIDEN	o,Ohio						
IV. TATTICK S					14. MOTHER 3 MAIDER							
15 WAS DES	Charles Hill	11.5	ocial ercupity No	1 17 0	150011111	Mary Su						
(Yes, no, or un	ASED EVER IN U.S. ARMED FORCES? known) (If yes give war or dotes	of service)	OCIAL SECURITY NO.		FORMANT		Addres					
No		?		Rol	bert W.Kel	Ly,3 N.Pe	nfield	Drive	,E.	G. Md.		
18. CAU	SE OF DEATH (Enter only one con RT I. DEATH WAS CAUSED BY:	use per line for	(o), (b), and (c).)							VAL BETWEEN		
h I	IMMEDIATE CAUSE	(o) Arte	riosclerot	ic Ca	ardiovascu	lar Disea	se.		UNSEI	AND DEATH		
	221 DUE	TO										
	s, if any, which gove ) nmediote couse (a),	(b)										
	he underlying couse DUE	TO										
last.	)	(c)					_					
PART II. (CELLICATION 200. EXT PRIMARY CALLS OF	OTHER SIGNIFICANT CONDITIONS (	CONTRIBUTING TO	DEATH BUT NOT RELA	ITED TO TI	HE TERMINAL DISEASE CO	ONDITION GIVEN IN	PART 1(o)			AS AUTOPSY REORMED?		
₽ 2Do. EXT	ERNAL CAUSE WAS	20b. DES	CRIBE HOW INJURY OC	CURRED. (I	Enter nature of injury in	n Part I or Port II of	item 18.1		1.03	X		
PRIMARY CAUSE OF	or CONTRIBUTING  DEATH				1-7							
₹ 20c. TIMI	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)									(Stote)		
	nour o.m. p.m.  19 While Not While of work of											
						, Inspection	, Inqui	ry 🔲,	ond ir	n my opinior		
deotl	n resulted from: Noture	ol couses 🗶	, Accident ,	Suicio	de, Homicid		ermined mo	nner 🗌				
ACTUAL	1/2/1/	V.	> ()		CHIEF MEDICA	AL EXAMINER						
SIGNATU	RE A DU	1 Us	ulas		_M.D. ASSISTANT ME	EDICAL EXAMINER 🛭			22.	DATE SIGNED		
EXAMINE NAME (T	R'S Rudiger Bre	iteneck	er, M.D/			CAL EXAMINER   et, city, town, or cou	unty)			8/31/6		
23a. BURIAL, O		EREOF	23c. NAME OF CEMET	ERY OR C	REMATORY	23d. LOCATIO	N (Citý or Towi	n) (Co	ounty)	(State)		
REMOVAL	(Specify) 9-2-	1966	Meadowr	idge		Elkrid		ì				
24. FUNERAL		o a Dull	ADDRESS		2So. REC	D BY REGISTRAR	25b. REG	STRAR'S SIGN	TURE	1.0		
F.C. H	ginbothom, Elli	cott Ci	t.v. Md		DATE	SEP 2 1	366 %	Mary	(es)	mage		
TOOTIT	Emino orions amount	COOD OT	O'A STEPY		DAIL					W		

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4		MARYLAND STATE D	DEPARTMENT OF HEALTH	
		Division of STATISTICAL RESEARCH AND RECORDS	S, 301 W. PRESTON STREET, BALTIMORE 1,	MARYLAND
TATE	_	11469 MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	11/69
DEPT.	1.	PLACE OF DEATH a. COUNTY . 4	2. USUAL RESIDENCE (Where deceased lived, If institution:	Residence before admission
		Howard MARYLAND	B. STATE Manlows b. COUNTY	tresard
		b. CITY ON TOWN (if outside corporete limits, write RURAL and give neerest town)  6. LENGTH OF STAY IN 1b	e. CITY OR TOWN (If outside corporate limits, write RURAL en	d give nearest town)
		SAVAGE	Savge	13-1
		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)	d. STREET ADDRESS	a. IS RESIDENCE
	1.3	BOOMADISON SI	300 Madeson Sti	YES NOW
	3.	NAME OF First Middle	Last 4. DATE Month	Dey Year
		(Type or print) 2456nne B. K.	IN FIE DEATH MY9.	25 1966
	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8.	DATE OF BIRTH  9. AGE (In yeers   IF UNDER 1   last birthday)  Anothe	YEAR IF UNDER 24 HRS.
		temale white widowed Divorced	9-16-01 64 yrs. Months	Deys Hours Min.
	10e do	a. USUAL OCCUPATION (Give kind of work no during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	IZEN OF WHAT COUNTRY?
		Clerk It. Magde	NEW HARTFORD COUNT C	SA
	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
	1	HNDREW BSULLAR	ANNA' BRASEL	
		WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17, III ss, no, or unkown) (Ifyas givewar or deles of service)	NFORMANT Address	1 d
		041-26-36600	onald K.Kinzie Javage	, reco
		PART I. DEATH WAS CAUSED BY:	6-1	ONSET AND DEATH
		IMMEDIATE CAUSE (e) COPONary	occlusion	Insteril
		· 4201 DUE TO		
		Conditions, if any, which (b)		
		(e), steting the underlying DUE TO		
		cause last. (c)		
_	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT	I RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1(a) 19. WAS AUTOPSY PERFORMED?
J	FICA	20%. EXTERNAL CAUSE WAS   20%. DESCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in Part I or Pert II of item 18.)	YES NO
	ERTI	PRIMARY   or CONTRIBUTING   CAUSE OF DEATH.	(crief nature of injury in Part 1 of Pert 11 of Item 18.)	
		20c. TIME OF INJURY Month, Dey, Yeer   20d. INJURY OCCURRED   20e. PLAC	CE OF INJURY (Home, ferm, † 20f. (City or town) (Coul	45
	MEDICAL	Hour a.m. While Not While fector	CE OF INJURY (Home, ferm, 20f. (City or town) (Courry, street, office bldg., etc.)	nty) (State)
	×	p.m. 19 at work et work	d an Autonov 🗍 (annovit 💆 )	
		21. I certify that I took charge of the remains described above, held		and in my opinion
		death resulted from: Natural causes. Accident . Suicident . Suicid	de, Homicide, Undetermined manner	
		ACTUAL HOW Z HALLA	CHIEF MEDICAL EXAMINER	
		SIGNATURE TOTALES,	M.D. ASSISTANT MEDICAL EXAMINER	DATE SIGNED
		NAME (Type) Thomas F. Herbert M.	DEPUTY MEDICAL EXAMINER A 44 Of wich R	2 1 25/11
	22a	BURIAL, CREMATION, 226. DATE THEREOF 224. NAME OF CEMETERY OR	Address (Street, city, town, or county) L//C/C	(Slete)
		REMOVAL (Specify) 8 29 166 (1)	MI and Roll To 1	1
	23	EUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR 1/4b. REGISTRAR'S SI	GNATURE
	1	Dewitt Donaldson 313 Tollathe I am	el Mel DATE SEP 1 4966 gelia	Men Judge
		Janes Mac College	THE TONIE TO I	1 -

THE HOLD CONTROL OF THE PROPERTY OF THE PARTY OF THE PART and the Artist Artist Artist and Artist and Artist DI ACE OF DEATH

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Aren please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or remarket, and in any event, within 72 hours ofter death.

O HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or ottending physician.

VR A15 (40 20 M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

470	CERTIFICATE OF DEATH	11464
ATU	2 IISHAL PESIDENCE (Where decented lived if institution	n: Pacidance bafara admission)

	a. COUNTY HOW	VARD		MARYLANC		CTATE	RYLAND b. (	ALIMITA	HOWAR		ong
	ELL COLL	(If outside corporate limi d give nancest tawn)	is,	c. LENGTH OF STAY IN 1b			rside corporate limits, write	RURAL and	give neore	est tawn)	,
	d. NAME OF HOSPIT	TAL OR INSTITUTION (If n	ot in hospital, g	give street address)		d. STREET ADDRESS				e. IS RESII ON A F	DENCE
L	RT. # 1	WATERLOO R	OAD			RT. # 1 W	ATERLOO. ROAD		357		NO [
3.	NAME OF DECEASED (Type ar print)		irst ATIE	Middle		NEIGHOFF		Nonth UGUST	Da	7, 196	36
S.	FAMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED		DATE OF BIRTH 11-20-1885	9. AGE (In year:	) Month	DER I YEAR Days	Hours	Min.
	a. USUAL OCCUPATION	N (Give kind af wark dane life even if retired)		ND OF BUSINESS OR DUSTRY			& State, or fareign cauntry) RYLAND	12	COUNTRY	A.	
13	. FATHER'S NAME					14. MOTHER'S MAIDEN N	AME		4 = 10		1 7
		JOSEPH BU	LLINGER	0.00		SARAH					
14	o, WAS DECEASED EVI (as, na, ar unknawn)	R IN U.S. ARMED FORCES? (If yes give war or dates	of convice t			NFORMANT WALTER NEI	GHOFF, 3618	ddress COOLI	DGE A	VENUI	3
	PART I. DEA  443  Conditions, if any rise to immedial stating the underlast.	te cause (a),	tha	Leven L.	V	s Lard	iv Vascu	las		TERVAL BET NSET AND D	
ATION	PART II. OTHER S	IGNIFICANT CONDITIONS	CONTRIBUTING 1	O DEATH BUT NOT RELATED	TO T	HE TERMINAL DISEASE CON	DITION GIVEN IN PART 1(a)			WAS AUTO PERFORM (ES	OPSY ED? NO
L CERTIFICATION		AS UNOERLYING  GAUSE OF DEATH MEDICAL EXAMINER)	205. DE	SCRIBE HOW INJURY OCCURE	RED. (	Enter nature of injury in f	art I ar Part II of item 1B.				
MEDICAL	20c. TIME OF INJ Haur o.	10	20d. If While at work	Not While		E OF INJURY (Hame, farm, pry, street, office bldg., etc.)	, 20f. (City ar tawn	)	(County)	(	State)
		ify that (I) (this ha		ded the desegsed fran			M, fam caus			hat (I) (1 te stated	
E	22a. SIGNATURE	Mank	E. Shi	fley	M.C		MED. STAFF DIRECTOR PHYS.	22b.	DATE SIGI	NED	
	22c. PHYSICIAN'S NAME (Type	FRANK	E. SHI	PLEY \		22d. ADDRESS 11 :	BALTIMORE ST	REET-	SAVAG	E, M	0.
23	a. BURIAL, CREMATION BURIAL Specify			23c. NAME OF CEMETERY MEADOWRIDGE			23d. LOCATION (City or BALT TMOR		(County MAR)	(S ZLAND	tate)
	4. FUNERAL DIRECTO		07 WILE	ADDRESS KENS AVENUE	2	25a. REC'D	G 11 1966	REGISTRAR	SSIGNATU	Judg	l.

MARYLAND STATE DEPARTMENT OF HEALTH of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND و مونة العالم MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: e. COUNTY b. COUNTY 성 files. MARYLAND b. CITY OR TOWN (if outside corporate limits, e. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL and give nearest town) director. write RURAL and give nearest town) your d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRES e. IS RESIDENCE ŏ ON A FARM? State YES NO 3. NAME OF 4. DATE Middle First Month Day DECEASED OF (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Hours DIVORCED YIS. 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) ve Pages 1, PM3. Page 13. FATHER'S NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 드 (Yes, no, or unkown) | (Ifyesgive war or detes of service) pue 18. CAUSE OF DEATH |Enter only one cause per line INTERVAL BETWEEN Office along burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ardiolescyler //sees e should writing the word "pending" in Conditions, if eny, which cremation, geve rise to Immediate cause Medical Examiner's DUE TO (a), steting the underlying certifical used cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e): 19. WAS AUTOPSY CERTIFICATION Pe PERFORMED? burial, NO S YES plnous 20s. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part | or Part || of item 18.) 0 PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. prior Chief / MEDICAL the Chie R: Page 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, ! 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Hour e.m. Not While agent, please execute the certificate, w 4 should be forwarded to the TO FUNERAL DIRECTOR: Pa Health or its designated agent, at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection 1 Inquiry W and in my opinion SICAL death resulted from: Natural causes Suicide Undetermined manner Accident Homicide CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) Address (Street, city, town, or county) 22a. BURIAL, CREMATION. 22b. OR CREMATORY 22c. 45tate REMOVAL (Specify) urral 24a. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE VR A15ME 966 5M 1/63

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in event, within 72 hours after deapt. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M 1/65 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11472
CERTIFICATE OF DEATH
11406

1.	PLACE OF DEAT a. COUNTY	Н			2. USUAL RESIDENCE (When a. STATE	re deceased lived, If Insti b. COUNT	itution: Residence before admission)
	How			MARYLAND	Maryland		loward
		VN (if outside corpora and give nearest tow		c. LENCTH OF STAY IN 1b	c. CITY OR TOWN (If outside	corporate limits, writ	e RURAL and give nearest town)
	Elkr		",		Elkridge		13.1
	d. NAME OF HO	SPITAL OR INSTITUTIO	N (if not in h	ospital, give street address)	d. STREET ADDRESS	5	e. IS RESIDENCE ON A FARM?
		Furnace Av			1942 Furnace		YES NO
3.	NAME DF DECEASED	Fi	rst	Middle	0		Day Year
-	(Type or print)	CHAR		ANCIS WEBER		EATH Aug. 2	28,1966 19
5.	SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH	last birthday)	FUNDER 1 YEAR   FUNDER 24 HRS.   Hours   Min.
102	Male	I White TION (Give kind of work			July 21,1904	62 yrs.	1 12. CITIZEN OF WHAT
dur	ing most of work	ing life, even if retire	d) 11	NDUSTRY	11. BINTHPLACE (County &	State, or foreign country)	COUNTRY?
	Painter				Maryland		
13.	FATHER'S NAM				14. MOTHER'S MAIDEN NAM		
	Cha	rles T. Webe	r .	14.	Alice Moore	- /**	MI SECTION EN
15 (Ye	. WAS DECEASED	EVER IN U.S. ARMED FO (If yes give war or dates o	RCES? 16.	SOCIAL SECURITY NO.   17.	INFORMANT	Address	
	No	(11)cogite ital of dates		3-14-6556 M	s.Emma M.Weber,	1942 Furnac	e Ave. Elkridge
	18. CAUSE OF	DEATH [Enter only on	e cause per l	ne for (a), (b), and (c).]	10	7	I INTERVAL BETWEEN
	PART I. D	EATH WAS CAUSED BY		andin	Maday	er fics	ONSET AND DEATH
	260X	IMMEDIATE CAUSE		0 4000	ya a com		100
Н	Conditions, if	any which \	1	7011000	1 Centar	in della	2301.16
	gave rise to	Immediate	(b)		1	100	20 04
	cause (a), s underlying cau		()	0 130.	to a alle	Phito	0 1
N			(c) NS CONTRIBO	TING TO DEATH BUT NOT RELA	TED TO THE TERMINAL DISEASE	CONDITION CIVEN IN P	ART 1(a) 119. WAS AUTOPSY
CATI				THE TOTAL SOL NOT KEE		00110111011011	PERFORMED? YES NO
CERTIF	20a. ACCIDENT OR CONTRIBUT	WAS UNDERLYING ING CAUSE OF DEA	TH 20b. [	PESCRIBE HOW INJURY OCCU	RRED. (Enter nature of Injury	In Part I or Part II of	Item 18.)
Ö	(IF EITHER, NO	TIFY MEDICAL EXAMI	VER)				
ICAI		INJURY Month, Day,		facto	CE OF INJURY (Home, farm, 20 ry, street, office bldg., etc.)	Of. (City or town)	(County) (State)
NED I	Hour a. p.	m. 19	While at work	Not while	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	21. [ certi	fy that (I) (this host	ital) attende	ed the deceased from	an 1964	to Gua 25	7. 1966, that (I) (we) last
		ceased alive on		2 42 1		from the causes a	nd on the date stated above.
	22a. SICNATU	RE A A					22b. DATE SICNED
	10	19/1/20	und	wards M.C	ATTENDING MED.	OR PHYS.	
	22c. PHYSTCI		a - Mil	0	22d. ADDRESS	10	- 97 M.
	NAME (T	Me) 18 18 B. B.	moshan	enst	Elle	rieg	e // //
23a	. BURIAL, CREM	MATION, 23b. DATE 1	HEREOF	23c. NAME OF CEMETERY	OR CREMATORY 23d.	LOCATION (City, tow	n or county) (State)
	Burial	8-31-	1.966	Meadowridge	104	kridge Md	
24.	FUNERAL HA	ECTOR	2011	ADORESS	ALLC		Charley Judge
3	July 2	othom. Ellie	att Cas	163	DATE AUG	1 1966	The sand
-		OCHORICAL LICE	DOD DOT	y , mu			8 -

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Charles Mandanie A.L.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH necessary, please exe-Rea. Dist. No 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH COUNTY b. COUNTY o. STATE MARTLAND Page 4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO 5 NAME OF Last DATE Day Year funeral retained far your DECEASED OF Winnieunki 7.2 (Type or print) 19 9. AGE (In years SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 8. DATE OF BIRTH IF UNDER TYEAR IF UNDER 24 HRS. 3 to the last birthday) Months Haurs Min. Days WIDOWED D DIVORCED with 10g. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) puo U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Pages 40 Page 16. SOCIAL SECURITY NO. 17. INFORMANT WAS DECEASED EVER IN U. S. ARMED FORCES? Address Give TERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Conditions, if ony, which pencil gave rise to immediate couse DUE TO (a), stoting the underlying cause lost. Office PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY 9 PERFORMED? YES | NO [ 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. shauld MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) EXAMINER: factory, street, office bldg., etc.) Hour While Nat while o. m. n 19 at wark at wark p. m. writing 21. I certify that I took charge of the remoins described abave, held an Autopsy Inspection ... Inquiry , and find that deoth resulted from: Notural couses . Accident . Suicide . Homicide . Undetermined couse MEDICAL DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER 00 SIGNATURE forwarded to FUNERAL ASSISTANT MEDICAL EXAMINER [ 44 **EXAMINER'S DEPUTY MEDICAL EXAMINER** NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or county) ADDRESS 23. FUNERAL DIRECTOR'S SIGNATULE 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. AISME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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